



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #:	M4-11-1340-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: WAL MART ASSOCIATES INC Box #: 53	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Required pain medication. Required Physical Therapy. Required MRI on both shoulders. Required fracture risk assessment. Parkland Health emergency admission for shoulders."

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Amount in Dispute: \$1,394.72

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Please note that the Self-Insured's initial notice of the injured employee's "Request for Reimbursement" was on January 6, 2011. The claimant did not submit their request in accordance with TDI-DWC Rule 133.307(c)(3)(D), prior to filing the MDR. Attached is a copy of the respondent's Affidavit of Non-Existence of Business Record. Since, the claimant failed to submit the "Request for Reimbursement" prior to filing a dispute this request should not be subject to MDR."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
02/25/10 – 11/08/10	EOBs or Denial Letter not submitted by either party	Out of pocket expenses for medication, physical therapy, MRI, Fracture Risk Assessment and Parkland Health emergency admission	\$1,394.72	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.

3. 28 Tex. Admin. Code §133.270 sets out the fee guidelines for the reimbursement of the out-of-pocket expenses incurred by the injured employee for their workers' compensation injury.

Issues

1. Did the requestor submit the request for medical dispute resolution in accordance with 28 Tex. Admin. Code §133.307?
2. Did the requestor submit receipts to the insurance carrier as required under 28 Tex. Admin. Code §133.270?
3. Is the requestor entitled to reimbursement?

Findings

1. The disputed dates of service range from 02/25/10 through 11/08/10; Medical Fee Dispute Resolution received the injured employee's request on December 27, 2010. Therefore, in accordance with 28 Tex. Admin. Code §133.307(c)(1) the disputed dates of service are eligible for review.
2. Review of the documentation submitted shows the injured employee did not submit receipts for the out of pocket expenses in accordance with 28 Texas Admin. Code Section §133.270(a). Therefore, in accordance with 28 Texas Admin. Code Section §133.307(e)(3)(I) the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter.

Conclusion

3. For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270
Texas Administrative Code Sec. §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.

01/26/2011

Authorized Signature

Auditor III
Medical Fee Dispute Resolution

Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.